Contact details:

Email: licensing@wokingham.gov.uk

Licensing, Wokingham Borough Council, Civic Offices, Shute End, Wokingham RG40 1BN

Phone 0118 974 6000

GROUP II MEDICAL EXAMINATION REPORT FORM

INFORMATION NOTES

It is a requirement under Section 57 of the Local Government (Miscellaneous Provisions) Act, 1976, to provide a Medical Examination Report to the effect that you are physically fit to drive a Hackney Carriage and / or Private Hire.

This form is to be completed by the applicant's own General Practitioner (GP) or another GP within the same practice and is for the confidential use of the Licensing Authority.

A Group II Medical Report Form is required on first licensing and thereafter from age 45, every five years until the age of 65. From the age of 65 a Group II Medical Report Form will be required annually.

Any fee charged is payable by the applicant directly to the Doctor

PLEASE COMPLETE IN BLOCK CAPITAL LETTERS IN BLACK

Licensing Officers **are not** permitted to complete or amend forms on behalf of applicants for legal reasons.

Patient's name		Date of Birth	

Medical Examination Report
To be filled in by the Doctor

The Patient must fill in sections 9 and 10 in the Doctor's presence (please use black ink)

• Please answer **all** questions.

Patient's weight (kg)	Height (cms)

Details of smoking habits if any
Number of alcohol units taken each week

Is the urine analysis positive for Glucose? (Please tick ✓ appropriate box)	**YES** ☐	**NO** ☐

Details of type of specialist(s)/ consultants, including address

1.	2.	3.	4.

Date of last Appointment

Date when first licensed to drive a motor vehicle

Patient's name		Date of Birth	

1. Vision

Please tick ✓ the appropriate

1. Is the visual acuity **at least** 6/9 in the better eye and at least 6/ 12 in the other? ■ (Corrective lenses may be worn) as measured with the full size 6m Snellen chart	**YES** ☐	**NO** ☐

2. Do corrective lenses have to be worn to achieve this standard? If **YES,** is the:	**YES** ☐	**NO** ☐
(a) uncorrected acuity at least 3/ 60 in the right eye?	**YES** ☐	**NO** ☐
(b) uncorrected acuity at least 3/ 60 in the left eye? (3/60 being the ability to read the 6/60 line of the full size 6m Snellen chart at 3 metres)	**YES** ☐	**NO** ☐
(c) correction well tolerated?	**YES** ☐	**NO** ☐

3. Please state the visual acuities **of each eye** in terms of the 6m Snellen chart.

Please convert any 3 metre readings to the 6-metre equivalent.

Uncorrected		**Corrected (if applicable)**	
Right	Left	Right	Left

4. Is there a defect in the patient's binocular field of vision (central and/or peripheral)?	**YES** ☐	**NO** ☐

5. Is there diplopia? (Controlled or uncontrolled)?	**YES** ☐	**NO** ☐

Does the patient have any other ophthalmic condition? If **YES** to 4, 5 or 6 please give details in **Section 7** and enclose any relevant visual field charts or hospital letters.	**YES** ☐	**NO** ☐

Patient's name		Date of Birth	

2. Nervous System

■

1. Has the patient had any form of epileptic attack? If **YES**, please answer questions a–f	**YES** ☐	**NO** ☐
(a) Has the patient had more than one attack?	**YES** ☐	**NO** ☐
(b) Please give date of first and last attack First attack Last attack		
(c) Is the patient currently on anti-epilepsy medication? If **Yes,** please fill in current medication on the appropriate section on the front of this form	**YES** ☐	**NO** ☐
(d) If treated, please give date when treatment ended		
(e) Has the patient had a brain scan? If **Yes,** please state: MRI ☐ Date CT ☐ Date Please supply reports if available	**YES** ☐	**NO** ☐
(f) Has the patient had an EEG? If **Yes,** please provide dates Please supply reports if available	**YES** ☐	**NO** ☐

2. Is there a history of blackout or impaired consciousness within the last 5 years? If **YES,** please give date(s) and details in **Section 7**	**YES** ☐	**NO** ☐

3. Is there a history of, or evidence of any of the conditions listed at a–g below? If **NO,** go to **Section 3.** If **YES,** please tick the relevant box(es) and give dates and full details at **Section 7** and supply any relevant reports.	**YES** ☐	**NO** ☐
(a) Stroke / TIA *please delete as appropriate* ■ If **YES**, please give date has there been a **full** recovery?	**YES** ☐	**NO** ☐
(b) Sudden and disabling dizziness/vertigo within the last 1 year with a liability to recur	**YES** ☐	**NO** ☐
(c) Subarachnoid haemorrhage	**YES** ☐	**NO** ☐

Patient's name		Date of Birth	

(d) Serious head injury within the last 10 years	**YES** ☐	**NO** ☐
(e) Brain tumour, either benign or malignant, primary or secondary	**YES** ☐	**NO** ☐
(f) Other brain surgery/abnormality	**YES** ☐	**NO** ☐
(g) Chronic neurological disorders e.g., Parkinson's disease, Multiple Sclerosis	**YES** ☐	**NO** ☐

3. Diabetes Mellitus

1. Does the patient have diabetes mellitus? If **NO,** please go to **Section 4.** If **YES,** please answer the following questions.	**YES**	**NO**
2. Is the diabetes managed by: (a) Insulin? If **YES**, please give date started on insulin (b) Exenatide / Byetta (c) Oral hypoglycaemic agents and diet? If **YES,** please fill in current medication on the appropriate section on the front of this form. (d) Diet only?	 **YES** ☐ **YES** ☐ **YES** ☐ **YES** ☐	 **NO** ☐ **NO** ☐ **NO** ☐ **NO** ☐
3. Does the patient test blood glucose at least twice every day?	**YES** ☐	**NO** ☐
4. Is there evidence of: (a) Loss of visual field? (b) Severe peripheral neuropathy, sufficient to impair limb function for safe driving? (c) Diminished/Absent awareness of hypoglycaemia?	 **YES** ☐ **YES** ☐ **YES** ☐	 **NO** ☐ V **NO** ☐ **NO** ☐
5. Has there been laser treatment for retinopathy? If **YES,** please give date(s) of treatment	**YES** ☐	**NO** ☐

Patient's name		Date of Birth	

6. Is there a history of hypoglycaemia during **waking** hours in the last 12 months requiring assistance from a third party? If **YES** to any of 4–6 above, please give details in **Section 7**	**YES** ☐	**NO** ☐

4. Psychiatric Illness

Is there a history of, or evidence of any of the conditions listed at 1–7 below? If **NO,** please go to **Section 5.** If **YES** please tick the relevant box(es) below and give date(s), prognosis, period of stability and details of medication, dosage, and any side effects in **Section 7.** **NB.** Please enclose relevant hospital notes.	**YES** ☐	**NO** ☐
NB. If patient remains under specialist clinic(s) ensure details are filled in at **the top of page 2**		
1. Significant psychiatric disorder within the past 6 months	**YES** ☐	**NO** ☐
2. A psychotic illness within the past 3 years, including psychotic depression	**YES** ☐	**NO** ☐
3. Dementia or cognitive impairment	**YES** ☐	**NO** ☐
4. Persistent alcohol misuse in the past 12 months ■	**YES** ☐	**NO** ☐
5. Alcohol dependency in the past 3 years	**YES** ☐	**NO** ☐
6. Persistent drug misuse in the past 12 months	**YES** ☐	**NO** ☐
7. Drug dependency in the past 3 years	**YES** ☐	**NO** ☐

5. Cardiac

Is there a history of, or evidence of coronary artery disease? If **NO,** go to **Section 5B.** If **YES,** please answer all questions below and give details at **Section 7** of the form and enclose relevant hospital notes.	**YES** ☐	**NO** ☐

5a Coronary Artery Disease

1. Acute Coronary Syndromes including Myocardial Infarction? ■ If **Yes,** please give date(s)	**YES** ☐	**NO** ☐
2. Coronary artery by-pass graft surgery? ■ If **Yes,** please give date(s)	**YES** ☐	**NO** ☐
3. Coronary Angioplasty (P.C.I) If **Yes,** please give date of most recent intervention	**YES** ☐	**NO** ☐
4. Has the patient suffered from Angina? If **Yes,** please give the date of the last known attack	**YES** ☐	**NO** ☐

Please go to next Section 5b

5b Cardiac Arrhythmia

Is there a history of, or evidence of, cardiac arrhythmia? ■ If **NO,** go to **Section 5C.** If **YES,** please answer all questions below and give details in **Section 7** of the form.	**YES** ☐	**NO** ☐
1. Has there been a **significant** disturbance of cardiac rhythm? i.e., Sinoatrial disease, significant atrio-ventricular conduction defect, atrial flutter/fibrillation, narrow or broad complex tachycardia in last 5 years	**YES** ☐	**NO** ☐
2. Has the arrhythmia been controlled satisfactorily for at least 3 months?	**YES** ☐	**NO** ☐
3. Has an ICD or biventricular pacemaker (CRST-D type) been implanted?	**YES** ☐	**NO** ☐
4. Has a pacemaker been implanted? If **YES:** (a) Please supply date (b) Is the patient free of symptoms that caused the device to be fitted? ■ ■ (c) Does the patient attend a pacemaker clinic regularly? ■	**YES** ☐ **YES** ☐ **YES** ☐	**NO** ☐ **NO** ☐ **NO** ☐

Please go to Section 5c

5c Peripheral Arterial Disease (excluding Buerger's Disease) Aortic Aneurysm/Dissection

Is there a history or evidence of ANY of the following: ■ If **YES,** please **tick** ✓ ALL relevant boxes below and give details in **Section 7** of the form. If **NO** go to **Section 5D.**	**YES** ☐	**NO** ☐
1. PERIPHERAL ARTERIAL DISEASE (excluding Buerger's Disease)	**YES** ☐	**NO** ☐
2. Does the patient have claudication? If **YES** for how long in minutes can the patient walk at a brisk pace before being symptom limited? Please give details	**YES** ☐	**NO** ☐
3. AORTIC ANEURYSM **IF YES:** (a) Site of Aneurysm: **Thoracic / Abdominal** ■ (b) Has it been repaired successfully? ■ (c) Is the transverse diameter **currently** > 5.5cms? ■ If **NO,** please provide latest measurement and date obtained	**YES** ☐ **YES** ☐ **YES** ☐	**NO** ☐ **NO** ☐ **NO** ☐
4. DISSECTION OF THE AORTA REPAIRED SUCCESSFULLY: If yes, please provide copies of all reports to include those dealing with any surgical treatment.	**YES** ☐	**NO** ☐

Please go to Section 5d

5d Valvular/Congenital Heart Disease

Is there a history of, or evidence, of valvular/congenital heart disease? If **NO,** go to **Section 5E** If **YES,** please answer all questions below and give details in **Section 7** of the form.	**YES** ☐	**NO** ☐
1. Is there a history of congenital heart disorder?	**YES** ☐	**NO** ☐
2. Is there a history of heart valve disease?	**YES** ☐	**NO** ☐

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3. Is there any history of embolism? (**Not** pulmonary embolism)	**YES** ☐	**NO** ☐
4. Does the patient currently have significant symptoms?	**YES** ☐	**NO** ☐
5. Has there been any progression since the last licence application? (If relevant)	**YES** ☐	**NO** ☐

Please go to section 5E

5e Cardiac Other

Does the patient have a history of **ANY** of the following conditions: ■	**YES** ☐	**NO** ☐
(a) a history of, or evidence of heart failure?	**YES** ☐	**NO** ☐
(b) established cardiomyopathy?	**YES** ☐	**NO** ☐
(c) a heart or heart/ lung transplant?	**YES** ☐	**NO** ☐
If YES, please give full details in Section 7 of the form. If NO, go to section 5f		

5f Cardiac Investigations

This section must be filled in for all patients

1. Has a resting ECG been undertaken?	**YES** ☐	**NO** ☐
If **YES,** does it show:		
(a) pathological Q waves? ■	**YES** ☐	**NO** ☐
(b) left bundle branch block? ■	**YES** ☐	**NO** ☐
(c) right bundle branch block? ■	**YES** ☐	**NO** ☐
2. Has an exercise ECG been undertaken (or planned)? ■	**YES** ☐	**NO** ☐
If **YES,** please give date and give details in **Section 7**		
Please provide relevant reports if available		

Patient's name		Date of Birth	

3. Has an echocardiogram been undertaken (or planned)? ■ (a) If **YES,** please give date and give details in **Section 7** (b) If undertaken, is/was the left ventricular ejection fraction greater than or equal to 40%? ■ *Please provide relevant reports if available*	**YES** ☐	**NO** ☐
4. Has a coronary angiogram been undertaken (or planned)? ■ If **YES,** please give date and give details in **Section 7** *Please provide relevant reports if available*	**YES** ☐	**NO** ☐
5. Has a 24-hour ECG tape been undertaken (or planned)? ■ ■ If **YES,** please give date and give details in **Section 7** *Please provide relevant reports if available*	**YES** ☐	**NO** ☐
6. Has a Myocardial Perfusion Scan or Stress Echo study been undertaken (or planned)? ■ ■ If **YES,** please give date and give details in **Section 7** *Please provide relevant reports if available*	**YES** ☐	**NO** ☐

Please go to Section 5g

5g Blood Pressure

This section must be filled in for all patients

1. Is today's best systolic pressure reading 180mm Hg or more?	**YES** ☐	**NO** ☐
2. Is today's best diastolic pressure reading 100mm Hg or more?	**YES** ☐	**NO** ☐
3. Is the patient on anti-hypertensive treatment?	**YES** ☐	**NO** ☐

If YES, to any of the above, please provide three previous readings with dates, if available

1.	**2.**	**3.**

Patient's name		Date of Birth	

6. General

Please answer all questions in this section. If your answer is 'YES' to any of the questions, please give full details **in Section 7.**	**YES** ☐	**NO** ☐
1. Is there **currently** a disability of the spine or limbs, likely to impair control of the vehicle? ■	**YES** ☐	**NO** ☐
2. Is there a history of bronchogenic carcinoma or other malignant tumour, for example, malignant melanoma, with a significant liability to metastasise cerebrally? ■ If **YES**, please give dates and diagnosis, and state whether there is current evidence of dissemination (a) Is there any evidence the patient has a cancer that causes fatigue or cachexia that affects safe driving? ■	**YES** ☐ **YES** ☐	**NO** ☐ **NO** ☐
3. Is the patient profoundly deaf? If **YES**, is the patient able to communicate in the event of an emergency by speech or by using a device, e.g., a text phone? ■	**YES** ☐	**NO** ☐
4. Is there a history of either renal or hepatic failure?	**YES** ☐	**NO** ☐
5. Is there a history of, or evidence of sleep apnoea syndrome? If ■ **YES**, please provide details (a) Date of diagnosis (b) Is it controlled successfully? ■ (c) If **YES**, please state treatment (d) Please state period of control (e) Please provide neck circumference (f) Please provide girth measurement in cms (g) Date last seen by consultant	**YES** ☐	**NO** ☐
6. Does the patient suffer from narcolepsy/cataplexy? If ■ **YES,** please give details in **Section 7**	**YES** ☐	**NO** ☐

7. Is there any other **Medical Condition**, causing excessive daytime sleepiness? If **YES**, please provide details (a) Diagnosis (b) Date of diagnosis (c) Is it controlled successfully? ■ (d) If **YES**, please state treatment (e) Please state period of control (f) Date last seen by consultant	**YES** ☐	**NO** ☐
8. Does the patient have severe symptomatic respiratory disease-causing chronic hypoxia?	**YES** ☐	**NO** ☐

9. Does any medication currently taken cause the patient side effects that could affect safe driving? ■ If **YES**, please provide details of medication	**YES** ☐	**NO** ☐
10. Does the patient have any other medical condition that could affect safe driving? ■■ If **YES**, please provide details	**YES** ☐	**NO** ☐
7. Please forward copies of relevant hospital notes only if deemed necessary. Please do not send any notes not related to fitness to drive.		

Patient's name		Date of Birth	

Patient’s name		Date of Birth	

8. Medical Practitioner Details

To be filled in by Doctor carrying out the examination

Name	**Surgery Stamp or GMC Registration Number**
Address	
Postcode	
Email address	
Fax number	

Medical Examination Report outcome:

	• Fit
	• Requires immunisation/vaccinations update on commencement.
	• Requires screening to meet requirements of Health & Safety at work legislation.
	• Must have Health Examination – appointment arranged.
	• Must have Health Examination – appointment to be arranged by Patient.
	• Awaiting outcome of correspondence.
	• Fit with restrictions – ***see recommendations***.
	• Unfit at present – ***see recommendations***.

Patient's name		Date of Birth	

	• Unfit

Recommendations:

I hereby certify that the patient examined is a registered with the surgery named above	
Signature of Medical Practitioner	**Date of Examination**

9. Patients Details

To be filled in by patient in the presence of the Medical Practitioner carrying out the examination

Your full name	Date of Birth
Your address	Home phone number
	Work/Daytime number
Postcode	Email address

Patient's name		Date of Birth	

Please make sure that you have printed your name and date of birth on each page before sending this form with your application.

10 Patient's consent and declaration

This section **MUST** be filled in and must **NOT** be altered in any way.

Consent and Declaration

I authorise my Doctor(s) and Specialist(s) to release report / medical information about my condition, relevant to my fitness to drive, to Wokingham Borough Council should the Council believe it necessary, to determine a licence application.

I authorise Wokingham Borough Council to release medical information to my Doctor(s) and or Specialist(s) about the outcome of my case where appropriate.

I declare that I have checked the details I have given on the enclosed questionnaire and that, to the best of my knowledge and belief, they are correct.

"I understand that it is a criminal offence if I make a false declaration to obtain a driving licence and can lead to prosecution."

Signature	**Date**